FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **NC**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Signature:

Mark T. Benton

SCHIP Program Name(s): **All, North Carolina**

SCHIP Program Type:

- ☐ SCHIP Medicaid Expansion Only
- ☒ Separate Child Health Program Only
- ☐ Combination of the above

Reporting Period: **2004** *Note: Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04.*

Contact Person/Title: **June Milby, Coordinator NC Health Choice**

Address: **NC Division of Medical Assistance, DHHS**

City: **Raleigh** State**:** **NC** Zip**:** **27699**

Phone: **919-855-4000** Fax: **919-715-0801**

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Submission Date: **2/14/2005**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

~~1)~~ To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						**From**	0	% of FPL conception to birth	0	% of FPL
	From		% of FPL for **infants**		% of FPL	**From**	185	% of FPL for **infants**	200	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL	**From**	133	% of FPL for 1 **through 5**	200	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL	**From**	100	% of FPL for children ages **6 through 16**	200	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL	**From**	100	% of FPL for children ages **17 and 18**	200	% of FPL

Is presumptive eligibility provided for children?	☐	No	☒	No
	☐	Yes, for whom and how long?	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☒	No
	☐	Yes, for whom and how long?	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	☐	No
		☒	Yes
		☐	N/A

Does your program have a mail-in application?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program over the phone?	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program have an application on your website that can be printed, completed and mailed in?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program on-line?	☐	No	☒	No
	☐	Yes – please check all that apply	☐	Yes – please check all that apply
	☐	Signature page must be printed and mailed in	☐	Signature page must be printed and mailed in
	☐	Family documentation must be mailed (i.e., income documentation)	☐	Family documentation must be mailed (i.e., income documentation)
	☐	Electronic signature is required	☐	Electronic signature is required
			☐	No Signature is required
	☐	N/A	☐	N/A

Does your program require a face-to-face interview during initial application	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☐	No	☒	No
	☐	Yes	☐	Yes
	Specify number of months		Specify number of months	
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	

			If the family requested a change through a TANF, Medicaid or SSI application, moved out of state, turns 19, dies, requests termination or purchases additional health insurance	
	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☐	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	50
	Premium amount		Premium amount	0
	Yearly cap		Yearly cap	50
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
			Enrollment fee of $50 for one child or $100 for two or more is required as a condition of enrollment for children in families above 150% FPL	
	☐	N/A	☐	N/A

Does your program impose copayments or coinsurance?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program impose deductibles?	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require an assets test?	☐	No	☒	No
	☐	Yes	☐	Yes
	If Yes, please describe below		If Yes, please describe below	
	☐	N/A	☐	N/A

Does your program require income disregards?	☐	No	☐	No
	☐	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
			$90 for each working adult, $17 for child care for child over age 2, $200 for age 2 and younger.	
	☐	N/A	☐	N/A

Is a preprinted renewal form sent prior to eligibility expiring?	☐	No	☒	No
	☐	Yes, we send out form to family with their information pre-completed and	☐	Yes, we send out form to family with their information pre-completed and
		☐ We send out form to family with their information pre-completed and ask for confirmation		☐ We send out form to family with their information pre-completed and ask for confirmation
		☐ We send out form but do not require a response unless income or other circumstances have changed		☐ We send out form but do not require a response unless income or other circumstances have changed
	☐	N/A	☐	N/A

Comments on Responses in Table:

~~2.~~ Is there an assets test for children in your Medicaid program? ☐ Yes ☒ No ☐ N/A

~~3.~~ Is it different from the assets test in your separate child health program? ☐ Yes ☒ No ☐ N/A

~~4.~~ Are there income disregards for your Medicaid program? ☒ Yes ☐ No ☐ N/A

~~5.~~ Are they different from the income disregards in your separate child health program? ☐ Yes ☒ No ☐ N/A

~~6.~~ Is a joint application used for your Medicaid and separate child health program? ☒ Yes ☐ No ☐ N/A

Enter any Narrative text below.

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
~~a)~~ Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☐	☐	☐	☒	☐
~~b)~~ Application	☐	☐	☐	☐	☒	☐
~~c)~~ Benefit structure	☐	☐	☐	☐	☒	☐
~~d)~~ Cost sharing (including amounts, populations, & collection process)	☐	☐	☐	☒	☐	☐
~~e)~~ Crowd out policies	☐	☐	☐	☐	☒	☐
~~f)~~ Delivery system	☐	☐	☐	☐	☒	☐
~~g)~~ Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☐	☐	☐	☒	☐
~~h)~~ Eligibility levels / target population	☐	☐	☐	☐	☒	☐
~~i)~~ Assets test in Medicaid and/or SCHIP	☐	☐	☐	☐	☒	☐
~~j)~~ Income disregards in Medicaid and/or SCHIP	☐	☐	☐	☐	☒	☐
~~k)~~ Eligibility redetermination process	☐	☐	☐	☐	☒	☐
~~l)~~ Enrollment process for health plan selection	☐	☐	☐	☐	☒	☐
~~m)~~ Family coverage	☐	☐	☐	☐	☒	☐
~~n)~~ Outreach (e.g., decrease funds, target outreach)	☐	☐	☐	☐	☒	☐
~~o)~~ Premium assistance	☐	☐	☐	☐	☒	☐
~~p)~~ Prenatal Eligibility expansion	☐	☐	☐	☐	☒	☐
~~q)~~ Waiver populations (funded under title XXI)						
Parents	☐	☐	☐	☐	☐	☒
Pregnant women	☐	☐	☐	☐	☐	☒
Childless adults	☐	☐	☐	☐	☐	☒

~~r)~~ Other – please specify

~~a.~~ _____ ☐ ☐ ☐ ☐ ☐ ☒

~~b.~~ _____ ☐ ☐ ☐ ☐ ☐ ☒

~~c.~~ _____ ☐ ☐ ☐ ☐ ☐ ☒

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

~~a)~~ Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
~~b)~~ Application	
~~c)~~ Benefit structure	
~~d)~~ Cost sharing (including amounts, populations, & collection process)	Copayments for prescription drugs were changed to encourage the use of generics. For the population below 150% FPL, copayments added were $1 for generic drug, $1 for brand with no generic available, and $3 for brand with generic. For population above 150%, copayments changed to $1 for generic, $1 for brand with no generic available, $10 for brand with generic available
~~e)~~ Crowd out policies	
~~f)~~ Delivery system	
~~g)~~ Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
~~h)~~ Eligibility levels / target population	
~~i)~~ Assets test in Medicaid and/or SCHIP	
~~j)~~ Income disregards in Medicaid and/or SCHIP	
~~k)~~ Eligibility redetermination process	

~~l)~~ Enrollment process for health plan selection	
~~m)~~ Family coverage	
~~n)~~ Outreach	
~~o)~~ Premium assistance	
~~p)~~ Prenatal Eligibility Expansion	
~~q)~~ Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
~~r)~~ Other – please specify	
a.	
b.	
c.	

Enter any Narrative text below.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures

- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

Adult Measures

- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:

- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous

enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in the first 15 months of life Not Reported Because: ☐ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*. HEDIS 2004 specifications (administrative specification)	Data Source(s): North Carolina Medicaid DRIVE data warehouse. TABLES: CLIENT_POPULATION (eligibility) CLIENT (recipient) HEALTH_CHOICE_CLAIMS (claims). Claims data from 01/01/2003 – 12/31/2003 Definition of Population Included in Measure: Age – 15 months old during measurement year. Continuous enrollment – 31 days thru 15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month birthday as the child's first birthday plus 90 days. Allowable gap – NC Medicaid verifies enrollment monthly. Member may not have more than a 1-month gap in coverage to be included in this measure. Anchor date – Enrolled on the day the child turns 15 months old. Delivery System of Care – HealthChoice. Baseline / Year: (Specify numerator and denominator for rates) NC HealthChoice did not extract data for this measure in years prior to this report. Denominator sample-size was too small to be significant.

Measure	Measurement Specification	Performance Measures and Progress
		Performance Progress/Year: (Specify numerator and denominator for rates) Rates are for eligibility and claims data for calendar year 2003. Denominator - 32 Numerator – Seven separate numerators are calculated, corresponding to the number of members who received zero, one, two, three, four, five, and six or more well child visits with a primary care practitioner during their first 15 months of life: Zero 3 One 0 Two 1 Three 1 Four 8 Five 12 Six or more 7 32 Rates – Zero 9.38% One 0.00% Two 3.13% Three 3.13% Four 25.00% Five 37.50% Six or more 21.88% 100.02% Explanation of Progress: This creates a baseline. Other Comments on Measure: NC HealthChoice submitted data for this measurement for 2002 claims data (submitted end of 2003). The data that was submitted was extracted per HEDIS 2003 specifications. However, the extract for HealthChoice clients alone yielded a very low number of clients. So, data for fee-for-service Medicaid clients were included with HealthChoice clients to produce the report. So, the results for that year can not be reasonably compared with this year's extract. CY2003 will serve as baseline for this measure for NC HealthChoice.

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in children the 3rd, 4th, 5th, and 6th years of life Not Reported Because: ☐ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*. HEDIS 2004 specifications (administrative specification)	Data Source(s): North Carolina Medicaid DRIVE data warehouse. TABLES: CLIENT_POPULATION (eligibility) CLIENT (recipient) HEALTH_CHOICE_CLAIMS (claims). Claims data from 01/01/2003 – 12/31/2003 Definition of Population Included in Measure: Ages – Three, four, five or six years old as of December 31 of 2003. Continuous Enrollment – Continuously enrolled during 2003. Allowable gap –Member may not have more than a 1-month gap in coverage to be included in this measure. Anchor Date – Enrolled as of December 31 of 2003. Delivery System of Care – HealthChoice. Baseline / Year: (Specify numerator and denominator for rates) NC HealthChoice submitted data for this measure for 2002 claims data (submitted end-of-year 2003). The data submitted will serve as baseline. 2002 rate – Numerator 3,814 = 55.50% Denominator 6,872 Performance Progress/Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) In this report, NC HealthChoice submits data for this measure for 2003 claims data. 2003 rate – Numerator 5,417 = 54.82% Denominator 9,881 Explanation of Progress: Rate remains steady despite increasing population.

Measure	Measurement Specification	Performance Measures and Progress
		Other Comments on Measure: Selected claims/places-of-service OUTPATIENT DEPT OFFICE PATIENT'S HOME OTHER Specifically excluded CPT codes regardless of the diagnosis codes: ANESTHESIA HA112 EMERGENCY DEPT VISIT 99281 EMERGENCY DEPT VISIT 99282 EMERGENCY DEPT VISIT 99283 EMERGENCY DEPT VISIT 99284 EMERGENCY DEPT VISIT 99285 DIRECT ADVANCED LIFE SUPPORT 99288 Only allowed the following billing provider specialty codes when determining well child visits : GP-GENERAL PRACTICE 012 I-INTERNAL MEDICINE 015 PEDIATRICS 030 PH-PUBLIC HEALTH 031 FP-FAMILY PRACTICE 041 MSP-MULTISPEC OR PDC 100 I-INTERNAL MED GROUP 115 PD-PEDIATRICS GROUP 130 INTERNAL MEDICINE 188 FAMILY NURSE PRACTITIONER 190
Use of appropriate medications for children with asthma Not Reported Because: ☐ Population not covered. ☐ Data not available. *Explain*.	☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*. Volume 2 NCQA HEDIS 2004 Technical	Data Source(s): NC SCHIP membership and claims data Definition of Population Included in Measure: Members ages 5-19 (the upper limit as permitted by product) by December 31 2003, who were continuously enrolled in both calendar years 2002 and 2003 (with no more than 1 month gap in enrollment) defined as persistent asthmatics (per NCQA specifications). Holding both medical and pharmacy benefit.

Measure	Measurement Specification	Performance Measures and Progress
☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	Specifications	Baseline / Year: (Specify numerator and denominator for rates) 2002 Measurement Year (Specify numerator and denominator for rates) 5-9 year olds 175/258 (67.83%) 10-17 year olds 312/493 (63.29%) 18-19 year olds 19/37 (51.35%) Combined 506/788 (64.21%) Performance Progress/Year: (Specify numerator and denominator for rates) 5-9 year olds 336/427 (78.69) 10-17 year olds 592/806 (73.45) 18-19 year olds 26/56 (46.43) combined 954/1289 (74.01) Explanation of Progress: NC State Employees Health Plan implemented an Asthma intervention plan during 2003 causing a significant improvement (10%). Other Comments on Measure:
Children's access to primary care practitioners Not Reported Because: ☐ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* ☐ Other. *Explain*. HEDIS 2004 specifications (administrative specification)	Data Source(s): North Carolina Medicaid DRIVE data warehouse. TABLES: CLIENT_POPULATION (eligibility) CLIENT (recipient) HEALTH_CHOICE_CLAIMS (claims). North Carolina Medicaid DRIVE data warehouse. TABLES: CLIENT_POPULATION (eligibility) CLIENT (recipient) HEALTH_CHOICE_CLAIMS (claims). Age stratification 1 and 2 - Claims data from 01/01/2003 – 12/31/2003. Age stratification 3 and 4 - Claims data from 01/01/2002 – 12/31/2003.

Measure	Measurement Specification	Performance Measures and Progress
		Definition of Population Included in Measure: Age stratification 1:12-24 months as of December 31, 2003. Age stratification 2:25 months to 6 years as of December 31, 2003. Age stratification 3:7-11 years as of December 31, 2003. Age stratification 4:12-19 years as of December 31, 2003. Continuous Enrollment Age stratifications 1 and 2: Continuously enrolled for all of 2003. Age stratifications 3 and 4: Continuously enrolled for all of 2002 and 2003. Allowable gap Age stratifications 1 and 2: No more than 1 month gap for the measurement year. Age stratifications 3 and 4: No more than 1 month gap during each year of continuous enrollment. Anchor date: Enrolled as of December 31, 2003. Delivery System of Care: Health Choice.
		Baseline / Year: (Specify numerator and denominator for rates) NC HealthChoice submitted 2002 claims data (submitted end-of-year 2003). This is the baseline. 2002 rates – Age stratification 1 Numerator 574 = 96.80% Denominator 593 Age stratification 2 Numerator 7,380 = 89.86% Denominator 8,213 Age stratification 3 Numerator 8,173 = 89.55% Denominator 9,127 Age stratification 4 Not defined in HEDIS 2003 specifications. This baseline is established with 2003 data.

Measure	Measurement Specification	Performance Measures and Progress
		Performance Progress/Year: (Specify numerator and denominator for rates) In this report, NC HealthChoice submits data for this measure for 2003 claims data. 2003 rates – Age stratification 1 Numerator 638 = 95.80% Denominator 666 Age stratification 2 Numerator 10,993 = 90.91% Denominator 12,092 Age stratification 3 Numerator 9,719 = 89.85% Denominator 10,817 Age stratification 4 Numerator 12,404 = 85.36% Denominator 14,532 NOTE - Regarding new age stratification 4 – The measure records clients who are ages 12-19 years old as of December 31, 2003. Technically, NC Health Choice only covers clients through age 18. Included in this report are 65 clients (of the 14,532 contained in the denominator for age stratification 4) who had their 19th birthday within December 2003 and were therefore aged out of Health Choice starting January 2004. However, they met the HEDIS 2004 enrollment criteria and received one or more MCO primary care visits prior to their 19th birthday and were therefore included in the study. For NC Medicaid, the age of a client is established as of the first day of the month (of eligibility) and remains fixed until the beginning of the next month. Explanation of Progress: Rate remains steady with increasing population. Note a 50% increase in the population of 2-6 year olds with consistent rate. Other Comments on Measure:
Adult Comprehensive diabetes care (hemoglobin A1c tests)		Data Source(s):

Measure	Measurement Specification	Performance Measures and Progress
Not Reported Because: ☒ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*.	Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
Adult access to preventive/ambulatory health services Not Reported Because: ☒ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
Adult Prenatal and postpartum care (prenatal visits): ☐ **Coverage for pregnant women over age 19 through a demonstration** ☐ **Coverage for unborn children through the SCHIP state plan**	☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates)

Measure	Measurement Specification	Performance Measures and Progress
☐ **Coverage for pregnant women under age 19 through the SCHIP state plan** Not Reported Because: ☒ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.		Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

SECTION IIB: ENROLLMENT AND UNINSURED DATA

~~1.~~ The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2003	FFY 2004	Percent change FFY 2003-2004
SCHIP Medicaid Expansion Program	0	0	
Separate Child Health Program	150,444	174,259	15

~~A.~~ Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

The low income population of the state has grown significantly due to numerous factory closings, business failures and layoffs. North Carolina ranks number one in the nation in loss of textile jobs. Additionally, NC has one of the fastest growing immigrant populations in the nation.

~~2.~~ Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2003. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FY 2004 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998	212	29.3	11.2	1.5
1997-1999	195	27.8	10.2	1.4
2000-2002	166	22.4	7.7	1.0
2001-2003	177	23.4	8.2	1.0
Percent change 1996-1998 vs. 2001-2003	(16.5)%	NA	(26.7)%	NA

~~A.~~ Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

Past data runs confirm that the CPS estimates for North Carolina grossly undercount the number of children in the Medicaid program. For example, the 2004 CPS estimates that there are 531,806 low income children covered by Medicaid or NC Health Choice. Our own data, based on pull check night in July 2004, show that there are 734,717 children covered.

~~3.~~ If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	Data source: The total number of children is based on 2003 data from the Office of State Budget and Management. Medicaid and NC Healht Choice enrollment numbers are from July pull check counts. Percents used to allocate children to poverty cells, and to calculate uninsured rates for individuals not covered by Medicaid and NC Health Choice are calculated using CPS 2002-2004 (calendar years 2001-2003).
Reporting period (2 or more points in time)	FFY 1997/ FFY 2004
Methodology	We began by calculating numbers for two cells, children ages 0-5 in families with incomes <200% FPL, and children ages 6-18 in families with incomes <200% FPL. In each age category, we starated with the total number of children regardless of income as identified by the Office of State Budget and Management, and then applying the percentage of those children who are in low income famlies calculated using the CPS). From this total, we subtracted the actual number enrolled in the Medicaid and NC Health Choice programs. For the the remaining children (those not covered by Medicaid or NC Health Choice), we applied the uninsurance rates estimated in CPS for children not covered by Medicaid or SCHIP in order to calculate the number of uninsured children.
Population	All children ages 0-18 who live in families with incomes <200 FPL.
Sample sizes	not applicable
Number and/or rate for two or more points in time	FFY 1997 Uninsured 126,4651 Total children 805,735 Percent uninsured: 15.7%. Current estimates: uninsured 82,407 total children 953,190 percent uninsured: 8.6%
Statistical significance of results	Because the methodology requires combining date from a number of sources, some of which include the entire populationn,a statistical significance cannot be calculated.

~~A.~~ Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

As noted in 2A, the CPS undercounts Medicaid enrollment for low-income children in North Carolina. Because Medicaid is the most common form of health insurance for this group of children, and because the NC Health Choice program also enrolls substantial numbers of children, we wanted a methodology that would capture actual enrollment in these programs.

~~B.~~ What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

With our revised methodology we know that the Medicaid and NC Health Choice numbers are accurate as they are based on actual program enrollment rather than estimates from a survey. We have confidence in the total population numbers from the Office of State Budget and Management. Unfortunately, our methodology still relies on the CPS to estimate the percent of children in low-income families, and to estimate the percent of children to estimate

the percent of children not enrolled in public insurance programs who are uninsured. Because of the problems with CPS discussed in 2A, we do not have complete confidence in these estimates but at this time we do not have an attendance source of date.

4. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program should skip this question.)***

Since the implementation of NC Health Choice (October 1, 1998) through July 1, 2004 a total of 667,468 children have been considered for Medicaid from the joint application for children's health insurance. Of these 481,694 have been enrolled. During the same time period, 554,118 children have applied and been considered for NCHealth Choice from the same joint application. Of these 371,093 have enrolled. Health insurance was considered for an additiona 726, 548 children applying for Medicaid. Of these children 191,951 enrolled.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3. Progress towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives Related to Reducing the Number of Uninsured Children ***(Mandatory for all states for each reporting year) (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)***		
☐ New/revised ☒ Continuing ☐ Discontinued Explain:	Goal #1: Reduce the number of uninsured children	Data Source(s): NC Office of State Budget and Management population estimates, actual NC Health Choice and Medicaid enrollment, percent of children by poverty level and uninsured from CPS Definition of Population Included in Measure: All children ages 0-18 in the state of NC who live in families with incomes below 200%FPL Methodology:] Methodology as reported in Section IIB,#3 Baseline / Year: (Specify numerator and denominator for rates) 14.5/ ffy 1999 numerator-estimated number of uninsured children ages 0-18 in families<200% fpl (119,081) denominator is total children ages 0-18 (820,528)

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Performance Progress / Year: (Specify numerator and denominator for rates) numerator-estimated number of uninsured children ages 0-18 in families<200% fpl (119,081) denominator is total children ages 0-18 (820,528) Percent uninsured in FFY 2004 8.6% Explanation of Progress: Over the last five years we have reduced the percentage of low income children who are uninsured by 5.9 percentage points. The absolute number of uninsured children has been reduced by 36,674 Other Comments on Measure: We believe that the decrease in the number and rate of uninsured children in NC reflects the continued success in enrolling eligible children in NC Health Choice. Although the decrease seen in the absolute number of uninsured children is smaller than the growth in the number of children enrolled in NC Health Choice between FY1999 and FY 2004, this is because of the growth in the total number of children during the same time period.
☐ New/revised ☐ Continuing ☐ Discontinued Explain:	Goal #2:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
☐ New/revised ☐ Continuing ☐ Discontinued Explain:	Goal #3:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates)

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

Objectives Related to SCHIP Enrollment

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
☐ New/revised ☒ Continuing ☐ Discontinued Explain:	Goal #1: To maintain SCHIP enrollment to fundable levels	Data Source(s): The Division of Medical Assistance Eligibility Information System (EIS) count of the number of enrolled children by actual per member per month costs of operating the program (DRIVE system). Definition of Population Included in Measure: The actual enrollment in NC Health Choice Methodology: Compare the number of children in the program to the actual number possible within allocated funds. [500] Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Progress is measured by the fact that funds were found to prevent the program from freezing in FFY 2004 Other Comments on Measure:
☐ New/revised ☐ Continuing ☐ Discontinued Explain:	Goal #2:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
☐ New/revised ☐ Continuing ☐ Discontinued Explain:	Goal #3:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
Objectives Related to Medicaid Enrollment		
☐ New/revised ☒ Continuing ☐ Discontinued Explain:	Goal #1: To enroll a full measure of children in Medicaid	Data Source(s): Medically Indigent Children (MIC) enrollment numbers in the Eligibility Information System Definition of Population Included in Measure: Medicaid children enrolled in the MIC category. These are children who enrolled as a result of effort to acquire health insurance for child on combined application form. Methodology: Compare the number of children enrolled as of the end of the federal fiscal year to children enrolled just before the program started in 1998 Baseline / Year: (Specify numerator and denominator for rates) : 1998/2004 Increased by a rate of 66% numerator: October 1, 1998: 231,891 eligibles in MIC (Medicaid Indigent Children). NC Health Choice for children opened on this date. Denominator: October 1, 2004: 384,325 eligibles in MIC (Medicaid Infants and Children) Performance Progress / Year: (Specify numerator and denominator for rates) There are now 152,434 more children enrolled in Medicaid than there were when NC Health Choice opened. The number of children enrolled is 66% greater than in 1998.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Explanation of Progress: The combined outreach for the Medicaid Children's Insurance Program with NC Health Choice has steadily grown both programs. Other Comments on Measure: The title of the category has changed, but reflects the same eligibility group.
☐ New/revised ☐ Continuing ☐ Discontinued Explain:	Goal #2:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
☐ New/revised ☐ Continuing ☐ Discontinued Explain:	Goal #3:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
☐ New/revised	Goal #1:	Data Source(s): Please see Section IIA

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
☒ Continuing ☐ Discontinued Explain:	☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* ☐ Other. *Explain*. To increase the access to primary care physicians. (please see HEDIS reported in Section IIA)	Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
☐ New/revised ☐ Continuing ☐ Discontinued Explain:	Goal #2: ☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* ☐ Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
☐ New/revised ☐ Continuing ☐ Discontinued Explain:	Goal #3: ☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* ☐ Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates)

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Explanation of Progress: Other Comments on Measure:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
☐ New/revised ☒ Continuing ☐ Discontinued Explain:	Goal #1: ☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* ☐ Other. *Explain*. improve the numbers of well child visits	Data Source(s): Please see Section IIA above. Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
☐ New/revised ☐ Continuing ☒ Discontinued Explain: Currently the information system is undergoing renovation and the only data that are available are the statewide data. To be able to select for NCHC alone will not be possible this year. According to the annual Child Health Report Card published by the NC Institute of Medicine. The immunization rate of all two-year-old children for 2004 is 85.3% up 3 percent from 1998. The rate for all children entering first grade is 99.6% up 1% from 1998.	Goal #2: ☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* ☐ Other. *Explain*. Improve Immunization rates	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
☐ New/revised ☐ Continuing ☐ Discontinued	Goal #3: ☐ HEDIS. *Specify version of HEDIS used.*	Data Source(s): Definition of Population Included in Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Explain:	☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*.	Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

2. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found?

] Periodic studies that are done. None were conducted by outside groups in 2004 in a cost-savings effort.

3. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

The ad-hoc Provider Task Force has agreed to serve as our policy committee. As such it will be determining what measures to collect and how to collect them. Some data may be available to report on as early as 2005. The Provider Task Force is an ongoing ad hoc group of representatives of provider organizations including hospitals, physicians, dental, vision, hearing, rural clinics, major medical centers, etc. Headed up by the NC Pediatric Society and the NC Family Care Association, the Provider Task Force maintains an ongoing policy link between the provider community and the program. Now taking on the role of a quality oversight body, the Provider Task Force examines benefits and advises program representatives on appropriate coverage decisions. The Task Force has been involved significantly in outreach efforts, particularly to families whose certification period is expiring and who need to reenroll.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

We have conducted an in depth look at claims data to determine how special health care needs were assessed. The study provided information that is currently being used to make quality of care improvements in the services provided through certain facilities.

5. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

Annual Utilization Report of Blue Cross and Blue Shield of North Carolina.

"Inpatient utilization decreased slightly during FY 2004. Overall, utilization was below the norm due to the large number of newborn admissions included in the norm.

"The average charge per admission increased for the Non-Copay segment and remained stable for the Copay segment. The average charge per day, however, decreased for the Non-Copay segment and was stable for the Copay segment.

"Respiratory diseases was the most common diagnostic category, accounting for close to one-fifth of all admissions. Injury and poisoning, digestive diseases, mental disorders, and endocrine diseases each accounted for 10 percent or more of admissions.

"Outpatient Utilization and Average Charges

Utilization rates for the total group were fairly stable and exceeded the norm in the hospital outpatient and emergency department settings in FY 2004. On the other hand, utilization by the total group fell slightly and was below the norm in the ambulatory surgery setting.

In the emergency room setting, the emergent, urgent, and non-urgent utilization rates were well above their norms. In both the hospital outpatient and emergency room settings, the average charge per visit for the total group was significantly lower than the norm, while the group's average ambulatory surgery charge was higher than the norm.

"Office Visit Utilization and Average Charges

The office visit utilization rate remained stable for both primary care providers and specialists. Utilization was comparable to the norm for the primary care setting, but slightly above the norm for the specialist setting. On the other hand, the average charge per visit was less than the norm for primary care visits, but greater than the norm for specialist visits.

"Overall, outpatient utilization of mental health services was greater than the norm. Visit rates for mental health, alcohol abuse and drug abuse each declined.

"Costly admissions (admissions which incurred payments greater than $50,000) accounted for over $1 per member per month."

Enter any Narrative text below.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

~~1.~~ How have you redirected/changed your outreach strategies during the reporting period?

Our outreach strategies fall into three areas of focus: (1) direct outreach to families and those who serve families; (2) simplification of enrollment/re-enrollment processes; and (3) encouraging families to make the best use of their insurance benefit once they are enrolled.

For FFY 2003-04, North Carolina continued to focus on outreach to schools and child care centers as a primary strategy for reaching families. Back to school enrollment drives are promoted through principals and school lunch directors. Exhibits, targeted mailings, inclusion of materials in conference packets are directed toward school nurses, social workers, psychologists and guidance counselors. Through regional meetings of Child Care Directors, 400 packets of information were disseminated. A targeted mailing promoting child health insurance programs was sent to 3500 licensed Child Care Centers. Outreach in the Child Care Community is being institutionalized by the distribution of electronic post cards to targeted audiences. Electronic post cards are succinct reminders re: the importance of doing outreach for child health insurance programs. Our State's TEACCH Early Childhood Education Project provides incentives for getting uninsured children of low wage child care staff covered through the state's child health insurance programs.

Staff continue to conduct training and do exhibits as a way to reach professional staff with updated information. We participate in quarterly orientation sessions for new staff to a variety of programs. We also exhibit at a host of professional meetings on an annual basis. As opportunities arise, we work with business and faith community outreach, but have found these efforts to be much more labor intensive and low yield.

Radio PSAs and interviews continue to allow us to focus outreach toward targeted segments of the population quite effectively. Minority-owned media recognize the value of airing these messages to the communities they serve. Television (Open Net Program and Univision) has also offered several opportunities over the past year to provide information about our programs to the Latino audience in an interview/call-in format.

Our Title V Resource Line (the NC Family Health Resource Line) continues to provide a toll-free number for families to call for information, referrals and advocacy in relation to our child health insurance programs. Approximately 63% of the 43,702 calls in FY 2003-04 and 64% of the materials mailed in response to calls pertain to Health Check/NC Health Choice. County agencies which call for these materials act as the "eyes and ears" for our program helping us to determine if our outreach efforts are effective and to learn about problems families are experiencing in getting enrolled and accessing services. This allows us to intervene on their behalf and to resolve bigger system issues as we notice trends in problem calls.

Perhaps the greatest accomplishment for our program in FFY 2003-04 was the development of our Health Check/Health Choice Outreach Web Site (http://www.nchealthystart.org/outreach/index.html). This web site offers a One-Stop-Shop for information and resources for folks doing outreach statewide. The web site features "New News"; Links to Data & Resources; Experiences to Share from Others Across the State; Local Outreach Contacts and more. This web site combined with the state-created outreach list serves offer us a very responsive communication vehicle. List serves that reach nearly 800 individuals across the state can be used to send out a time-urgent single-issue communication and they can be used to announce the addition of new articles to our web site with hotlinks from the email. We also use list serves to distribute surveys for local input as we update and improve our offering of outreach materials annually. The list serve linked to the outreach web site has replaced newsletters and other more cumbersome communication efforts. The web site was developed with the input of state and local staff. Online local information is updated annually through a survey and ad hoc as individuals contact us.

The HC/NCHC Family Web Site (http://www.NCHealthyStart.org/programsHCHC.html), which is also updated annually, continues to provide online information and links to resources (e.g. application forms; benefits booklets) for families and the public.

The DMA NC Health Choice Web Site (http://www.dhhs.state.nc.us/dma/cpcont.htm) continues to be a primary resource for professionals, administrators and the public for a wealth of information regarding our State's CHIP Program.

For targeted outreach efforts, see response to Question #3 below.

An important strategy in successful outreach / enrollment is the simplification of enrollment and re-enrollment processes. State outreach staff continue to work collaboratively with staff of the NC Division of Medical Assistance to develop family-friendly, low literacy, simplified and Title VI compliant notices, application forms and re-enrollment forms.

A new outreach focus this year has been our efforts to encourage families to make the most of their health insurance benefit. Our SCHIP Benefits Booklet, the first piece families receive after enrolling in the program (along with their insurance card) now sports a cover promoting a five-step process to "Make the Most of Your NC Health Choice Benefit."
(http://www.dhhs.state.nc.us/dma/CHIP/NCHC2004.pdf)

North Carolina also launched a new Campaign: "The Right Call Every Time: Your Medical Home." Intended to stem inappropriate use of the Emergency Room for routine primary care services, the campaign promotes: (1) the value of preventive services; (2) the importance of having a consistent source of primary care services, and (3) the importance of a medical home for children with special health care needs. The Campaign also targets educational information on the top three illnesses that result in inappropriate use of the Emergency Room, especially for children 0-5, which are fever, colds

and flu, and ear infections. The Campaign was developed with heavy input from primary care providers and parents. The materials currently include a medical home brochure, magnet, 5 educational bookmarks, and a coloring book. To view materials, go to http://www.nchealthystart.org/outreach/prognews/medicalhomeinaugural.html.

Future development will focus on the medical home issue for children with special health care needs which will support NC's Medical Home Learning Collaborative.

The Medical Home Campaign was launched in late July-early August 2004 with dissemination of information and materials to a broad professional audience via list serves (linked to the above web site), newsletter articles, and direct mailing. The Campaign has been very well received with over 400,000 materials distributed in the first 2 months. Through pilot projects we will be evaluating the effectiveness of these materials, in combination with direct outreach/education by staff, at reducing inappropriate use of the emergency room.

The State and the NC Healthy Start Foundation have partnered with two grant-funded initiatives (RWJF's Covering Kids and Families and a Rex Foundation Project) to pilot and accomplish many of these objectives. A State Outreach Coalition continues to guide our efforts and assist in Work Plan development.

~~2.~~ What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

North Carolina has found that outreach through schools, child care centers, health care professionals, and targeted outreach to minority populations and families of children with special health care needs have been our most effective outreach strategies. This belief was informed by "lessons learned" from our first cycle of RWJF "Covering Kids" Funding. Their final report, "North Carolina Covering Kids: A Retrospective", documents these findings and is online at our HC/NCHC Outreach Web Site. In addition, we learn which outreach efforts have the most impact through the volume of calls to the NC Family Health Resource Line and from logged responses to a question asked of callers, "How did you learn about the resource line?" The continued growth of our SCHIP enrollment is also indicative of the success of our overall efforts.

Last, but not least, the local departments of social services (DSS) are key to outreach / enrollment success as they work with families who apply for various programs and recognize the opportunity to enroll children in either Health Check (our Medicaid Program for Children) and NC Health Choice. Our seamless outreach / enrollment process for these two programs has assured that children experience a smooth transition between the two programs as their family's economic situation fluctuates. All outreach / enrollment materials work for both programs. The same local DSS staff process applications and re-enrollment forms, and the same computer system (EIS) is used to track the eligibility status of children in these programs. These systems ensure that once children are enrolled in either program, their continued eligibility is determined through a seamless process.

~~3.~~ Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

North Carolina has a full-time permanent position, a State Health Check/NC Health Choice Minority Outreach Consultant, that focuses on targeted outreach to minority populations. To address the needs of the Latino Community, this position partners with the Latino Outreach Coordinator at the North Carolina Healthy Start Foundation (NCHSF). The Foundation is a statewide non-profit focused on improving the health of children in North Carolina. The State's Title V agency (NC Division of Public Health) contracts with this Foundation for their Campaign and materials development expertise.

In FFY 2003-04, extensive efforts were made to target outreach to the Native American, Hispanic/Latino and Hmong populations in NC. The outreach strategies mentioned in Question 1 work effectively for urban and rural populations and for minority outreach to the Black Population, but more targeted efforts are required for the populations listed.

The focus of these efforts was determined by comparing the number of specific minority children enrolled in the program to minority population density mapping. Using census block groups and tracts data, the State Center for Health Statistics put together a set of maps, which were used in conjunction with other known facts about minority populations to determine outreach priorities. These maps are also available on our HC/NCHC Outreach Web Site.

Statewide Efforts / Partnerships:

The NC Hispanic Chamber of Commerce holds monthly meetings at which the State and the NCHSF are present to distribute material and network with business owners /representatives who either serve or are a part of the Latino Community in NC. At these meetings, over 30 small businesses have received information on the program with five taking an active role in providing their employees and customers with applications (English and Spanish) and bilingual outreach materials.

The State and the NCHSF were active participants at the health fair La Fiesta del Pueblo, NC's largest educational and cultural statewide event. Participants exceeded 65,000 with a large number of them either receiving or hearing information about the programs.

The state's minority outreach consultant attended 10 out of 12 meetings organized and hosted by the Governor's Office of Hispanic and Latino Affairs. Many state and community organizations attend these meetings to exchange program information and discuss ideas and barriers in serving the Latino community.

Collaborations with the Raleigh-based Office of the Mexican Consulate provided the opportunity for participation in 5 consulate visits across the state at which a minimum of 15,000 families received program information and materials. Additionally, on average 2 community-based organizations per visit were provided technical assistance on enrolling children into the program. The consulate staff is now knowledgeable about the program and able to assist in enrolling children.

Latino media aired Spanish language PSA's provided by the NCHSF and a major Spanish language television station (Univision) invited the NCHSF to participate in a program to discuss children's health insurance.

The NC Center for International Understanding sent a group of health professionals, (which included the NC DHHS Secretary Hooker-Odom), to Mexico to get a better understanding of the health care system there and the community's beliefs regarding access to health care. The Center challenged the group to implement change to their health access programs based on the knowledge gained as a result of the experience. The State and the NCHSF plan to collaborate in the development of a low literacy picture story (fotonovella) that will help bridge this cultural gap by explaining our health care system and dispelling myths that create barriers to access for our State's child health insurance programs.

The state actively participates in a Migrant/Latino Work Group organized and hosted by the NC Community Health Center Association to learn about the challenges and barriers faced by Latinos in accessing care. This meeting allows outreach staff from community health centers to network and learn about programs and receive updates.

The State's Minority Outreach Consultant and the NCHSF's Latino Outreach Coordinator both serve on the state's Latino Health Task Force addressing issues of access to health care.

The State's Consultant serves on the American Indian Health Task Force co-chaired by the NC Commission of Indian Affairs and the NC DHHS Secretary. Through this task force and the access to care committee, the state works on improving access to health care for the American Indian population in NC.

The State's Consultant actively participates in the statewide Refugee Resettlement Advisory Council Meetings and provides technical assistance and training on the program to 18 plus resettlement agencies.

The State's Consultant has also begun work with the Latino Community Development Center to ensure that the over 40 Latino community centers have access to program information/materials and feel confident in providing assistance to families who want to enroll and re-enroll in the program.

Regional and Local Efforts:

The NCHSF and the State have conducted focus groups to improve the Spanish language materials and to gather information re: barriers in accessing health insurance coverage for their children. This information will be used in the development of the fotonovella mentioned previously.

The State's Minority Consultant has been able to participate in several interviews and talk shows on Spanish language radio/television stations and rural community radio stations.

Five local Latino centers have requested and received one-on-one training on the program.

The United Hmong Association of NC has provided information about the program on a local radio station, provided program information to its 18 clan leaders, and is in the process of translating a program brochure into Hmong. The Association has been collaborating with the state to get information out and help families enroll their children.

All the state and federally recognized Indian tribes in NC have received material and training on the program and can assist families in enrolling children.

Local faith leaders in the Latino, American Indian, Hmong and African American communities have received program information and materials. In addition, the State consultant has attended many powwows, Latino health and community fairs, and meetings of community based organizations.

In addition to anecdotal data and feedback from focus groups and the targeted communities themselves, we have tracked an increase in enrollment numbers.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

~~1.~~ Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted?

- ☐ Yes
- ☒ No
- ☐ N/A

If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

~~2.~~ Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions?

- ☐ Yes
- ☒ No
- ☐ N/A

If yes, identify your substitution prevention provisions (waiting periods, etc.).

All States must complete the following 3 questions

~~3.~~ Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

At the time of application, a family may have insurance but may not have it when they enroll. If they choose to close an existing insurance policy before enrollment, the child's NC Health Choice status will not begin until the first day of the month following dropping of private insurance coverage.

~~4.~~ At the time of application, what percent of applicants are found to have insurance?

Since this provision was implemented (February, 2002) through September 30, 2004 a total of 136 NC Health Choice cases dropped coverage. This represents .07% of children found eligible in that same period of time.

~~5.~~ Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

Less than one percent

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

~~1.~~ Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

North Carolina has the same redetermination procedures to renew eligibility for Medicaid and SCHIP. There is one application for redetermination that is returned to and processed by the

county Department of Social Services. It is reviewed based on family income by a county eligibility worker. If the child is determined to be Medicaid eligible the child is enrolled in Medicaid. If the child is determined to be SCHIP eligible, the child is enrolled in SCHIP. The family is subsequently informed of its eligibility status and the child receives a card reflecting his or her eligibility status.

2. Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

North Carolina's process is so seamless that the biggest problem we face is that, occasionally, a Medicaid family does not realize initially that the child has been moved into NC Health Choice (SCHIP in NC). Because the Medicaid card is larger and does not have the imprint of Blue Cross and Blue Shield of North Carolina as the SCHIP card does, the same problem does not occur in reverse.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

SCHIP in North Carolina uses an any-willing-provider indemnity system so that a previously Medicaid child does not have to change physicians or other providers when moving into SCHIP. Medicaid does have a broad network of providers and uses a PPO system. Medicaid also initiates reminder calls to patients for well-child checkups. NC Health Choice does not offer this feature.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

☐ Conducts follow-up with clients through caseworkers/outreach workers

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program?
  4
- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)
  A post card is mailed 10 calendar days before the re-enrollment form is mailed. The post card reminds them the re-enrollment form is coming and to return the form to the county department of social services. The re-enrollment form is mailed at the beginning of the 11th month of the certification period. A timely notice is mailed if the re-enrollment form is not returned by the 25th day of the 11th month. This timely notice gives recipient 10 work days to return needed information. After the

☐ Sends targeted mailings to selected populations

- Please specify population(s) (e.g., lower income eligibility groups)

☒ Holds information campaigns

☒ Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

The applicatiaon form has been tested for readability and is now two pages, front and back with ample white space. It is a combined application form.

☐ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment *please describe:*

☐ Other, *please explain*:

~~2.~~ Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

A post card is mailed 10 calendar days before the re-enrollment form is mailed. The post card reminds them the re-enrollment form is coming and to return the form to the county department of social services. The re-enrollment form is mailed at the beginning of the 11th month of the certification period. A timely notice is mailed if the re-enrollment form is not returned by the 25th day of the 11th month. This timely notice gives recipient 10 work days to return needed information. After the 10th work day, a notice is mailed to the recipient telling him the status of his case.

~~3.~~ Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

☒ Yes
☐ No
☐ N/A

When was the monthly report or assessment last conducted?

This report is run twice each month. The information provided is for the month of September, 2004-- the end of the federal fiscal year.

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
5,948	2,449	41	0	0	16	0	18	0	3,266	55

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

Items collected :

1. Report number 1 is as of the date of pull check, Report number 2 is enrollment as of the end of the ten day grace period

2. Total number eligible to reenroll 1) 13,211; 2) 13,211

3. Total number who reenrolled 1) 5,977; 2) 7,263

4. Percentage of those who reenrolled 1) 45.24% ; 2) 54.9%

5. Reenrollees found eligible for Medicaid 1)1,739; 2) 2,123

6. Percent of those eligible found eligible for Medicaid 1)13.16%; 2) 16%

7. Those eligible to purchase extended coverage (200%fpl-225%fpl); 1) 309; 2) 326

8. Percent of those eligible to purchase extended coverage (200%fpl-225%fpl) 1) 2.33%; 2) 2.4%

9. Number who termed reason unknown 1) 3,696; 2) 2,096

10. Percent who termed reason unknown 1) 27.97%; 2) 15.8%

11. Number who termed for a variety of reasons –aged out, moved, etc. 1) 1490; 2) 1,168

a. Number who of children who moved out of North Carolina –18

b. Number of children who no longer meet age requirements—16

c. Number who failed to pay the enrollment fee--145

12. Percent who termed for a variety of reasons—aged out, moved, etc. 1) 11.27% 2) 8.6%

13. Those with applications pended 1) -- 2) 235

14. Percent with applications pended 1) -- 2) 1.7%

The only complete unknown (because they did not attempt to reenroll) are those who are termed for reasons unknown. These 1,168 individuals (or 19.6% of the total who disenrolled) did not choose to return any information to the county social services department. There have been some spotty efforts (focus groups, surveys) to find out the reasons why those who don't reenroll choose not to. The most frequently cited reasons range from "I was too busy, " "I forgot," "my children are well right now," to "I got insurance for them through work." Efforts are underway to conduct a more detailed statewide survey to see if reasons can be better determined. We have no feedback that there was dissatisfaction with the program or with the care they received.

(Note: because your format does not allow decimals or "less than" notations, the "0" percentages above are not always reflective.

COST SHARING

~~1.~~ Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

North Carolina asks eligibility workers who make eligibility determinations to document the reasons for denial by places the application was filed. This is a monthly report accumulated by state fiscal year. Consistently the enrollment fee is in the top three reasons for denial (not counting administrative error). The other two reasons for denial are that the family "makes too much money," or "already has insurance." For the first few years of the program, failure to pay enrollment fee was the number one reason for denial. As a result, in several counties, local philanthropic organizations offer to pay this fee for those who need it. Enrollment fees apply only to those who make over 150% of the federal poverty level. That group comprises approximately 20% of the NC Health Choice population.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

No such assessment has been made. Co-payments are fees kept by providers to offset their costs. They can also be waived by providers if they so choose.

3. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found?

Copayments for prescription drugs were altered slightly (by the NC General Assembly) in an effort to encourage the use of less expensive generic medicines. No study has been conducted to determine whether or not this has impacted usage.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

☐ Yes, please answer questions below.
☒ No, skip to Section IV.

Children

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan
☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan (Incidentally)
☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

☐ Parents and Caretaker Relatives
☐ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.)

4. What benefit package does the program use?

~~5.~~ Does the program provide wrap-around coverage for benefits or cost sharing?

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured?

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced?

9. During the reporting period, what accomplishments have been achieved in your premium assistance program?

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned.

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.)**

Enter any Narrative text below.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2004. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2004**	**2005**	**2006**
Insurance payments	219,729,302	275,319,194	313,314,848
Managed Care			
per member/per month rate @ # of eligibles	150	169	171
Fee for Service			
Total Benefit Costs	219,729,302	275,319,194	313,314,848
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	$ 219,729,302	$ 275,319,194	$ 313,314,848

Administration Costs			
Personnel	93,238	127,374	150,784
General Administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	431,769	913,786	913,786
Other county administrative/eligibility determination	4,456,036	1,389,568	1,389,568
Health Services Initiatives			
Total Administration Costs	4,981,043	2,430,728	2,454,138
10% Administrative Cap (net benefit costs ÷ 9)	24,414,367	30,591,022	34,812,761

Federal Title XXI Share	166,285,655	207,034,792	235,058,433
State Share	58,424,690	70,715,130	80,710,553

TOTAL COSTS OF APPROVED SCHIP PLAN	224,710,345	277,749,922	315,768,986

2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement
- ☐ Other (specify)

Enter any Narrative text below.
Your format does not permit decimal points therefore the pmpm amounts are not accurately stated. The actual amounts are: 150.18, 168.85 and 171.32.

The State Appropriations allocated to DSS for County Administration support the $1,389,568; however the DSS total certified budget is $5.3 million

The Outreach costs are budgeted $1,084,675; however, The Division of Public Health will support the remaining expenditures.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

~~1.~~ If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

~~3.~~ What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

~~4.~~ Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	2004	2005	2006	2007	2008
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3
(e.g., pregnant women)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4
(e.g., childless adults)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)*					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)?

Please provide a description of any assumptions that are included in your calculations.

Other notes relevant to the budget:

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

~~1.~~ For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

] North Carolina continues to experience a lag in its recovery from the loss of tens of thousands of jobs from 2000 to the present time. New employers are slowly coming back into the state. Competition for any new jobs is fierce—particularly from those displaced from other states and countries looking for work.. In addition to the impact of actual jobs lost, is the impact of workers whose hours have been reduced and those whose health plan benefits have been eliminated or who have had reductions that eliminated dependent coverage. Each of these has increased the need for SCHIP services. Despite these factors, the Governor and the NC General Assembly have continued to identify resources to support NC Health Choice for Children.

~~2.~~ During the reporting period, what has been the greatest challenge your program has experienced?

The greatest challenge of the period has been to keep the program open and permit some limited outreach to occur within the existing budget.

~~3.~~ During the reporting period, what accomplishments have been achieved in your program?

Health Choice has grown steadily at one percent a month. Careful monitoring of some high level behavioral health services and efforts to encourage preventive health care and the least costly approach to care (such as the increasing of pharmacy benefits management) has held costs as low as possible within the benefits plan. To date, NC has not been faced with the imposition of severe service limits. The NC General Assembly has also granted the Secretary of the Department of Health and Human Services the authority to modify the service array for special needs children enrolled in NC Health Choice. They have also given the Secretary the authority to transfer state funds within the Department to cover a program shortfall.

~~4.~~ What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

Planned changes include adding the ability to subrogate benefits to continue in ongoing efforts to maximize all available dollars. It is widely anticipated that the 2005-2006 NC General Assembly will continue to examine the possibility of changing some or all of the benefits structure of the program in efforts to guarantee that all eligible children can enroll in the program. It is also possible that the legislature could impose a freeze or "rolling enrollment cap" to keep to keep overall expenditures from exceeding budgeted state funds.

Enter any Narrative text below.